MORE: MOBILE OUTREACH RETENTION AND ENGAGEMENT INTERVENTION

CIE Center for Innovation and Engagement

Funding Background

The Health Resources and Services Administration's (HRSA's) Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, essential support services, and medications for low-income people with HIV. RWHAP funds states, cities, counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission.

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Acknowledgments

NASTAD Authors:

Rachel Browning, Manager, Health Equity
Milanes Morejon, Senior Manager, Health Equity
Rosy Galván, Senior Director, Health Equity

Intervention Development Team:

Meghan Davies, Chief Program Officer
Britt Walsh, Director of Gender Affirming Services
Megan Dieterich, Mobile Medical Provider
Emani Sargent, Retention and Engagement Manager
Robert Bangert, Senior Manager of Care Navigation

Contributors

Natalie Cramer, Deputy Executive Director, NASTAD
Marné Garretson, NASTAD Consultant
Bria Mirante, Impact Marketing + Communications
Tara Kovach, Impact Marketing + Communications
Sarah Cook-Raymond, Impact Marketing + Communications

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CIE Equity in Evaluation Project Background

The Center for Innovation and Engagement (CIE) identifies, catalogs, and disseminates evidence-informed interventions. Interventions within the CIE compendium were identified through literature reviews of academic journals, key informant interviews, conference abstract reviews, and requests for information (RFI) surveys. In collaboration with Northwestern University, an evidence rubric based on the CDC's Prevention Research Synthesis (PRS) criteria was developed to gauge the effectiveness of interventions in improving patient outcomes. Interventions that met the inclusion criteria were reviewed by an Evidence and Dissemination Expert Panel (EDEP), which consisted of experts working across various HIV services and specialties. Each intervention received an "impact score," measuring its relevance, acceptability, appropriateness, feasibility, transferability, and sustainability. The EDEP selected sixteen interventions for the CIE team to include in the compendium. Most of the interventions chosen were published in academic journals.

Following the intervention identification process, the CIE team recognized that a number of innovative intervention models were excluded from the compendium because they lacked the necessary evaluation resources to meet evidence criteria. Using a research equity approach, the CIE team identified three additional promising interventions from the RFI list that did not meet the established evidence threshold and were not identified in the academic literature review process. These interventions were selected to participate in the CIE Equity in Evaluation Project. This project aims to provide organizations that developed innovative service delivery models with evaluation support. Interventions chosen for the project include the Detroit Health Department's Link-Up Rx program, Whitman-Walker Health's Mobile Outreach Retention and Engagement (MORE) program, and the Rhode Island Executive Office of Health and Human Services (RI EOHHS) TAVIE Red program.

Intervention teams were paired with consultants who have experience conducting a rigorous evaluation of programs serving people with HIV. Consultants prepared evaluation reports for the three interventions outlining key evaluation findings (e.g., program effectiveness, specific sub-population data) and strategies to sustain or expand future evaluation efforts. The intent is that organizations will use the findings from the analysis to enhance their programs, disseminate their innovative service delivery models, and add to the field of evidence-informed approaches that link, retain, and re-engage people with HIV in care. The inclusion of these three interventions in the Equity in Evaluation Project aims to highlight the need to (1) Increase capacity for health departments and community-based organizations to evaluate and demonstrate the impact of their programs in improving health outcomes for people with HIV, (2) Integrate equity frameworks to improve research and evaluation efforts, (3) Prioritize the work of agencies who may not have the capacity for high-level data management and analysis or who have limited funding to conduct rigorous analysis and disseminate findings, (4) Highlight and disseminate the work of agencies providing services to priority populations experiencing inequitable outcomes in HIV care and retention (e.g., transgender and non-binary people, people who use drugs, Black gay, bisexual, and other men who have sex with men).

This intervention guide outlines key findings from the evaluation of the Whitman-Walker Health (WWH) Mobile Outreach Retention and Engagement (MORE) intervention.

Considerations for the Ryan White HIV/AIDS Provider (RWHAP) Community

The dissemination of evidence-informed interventions and best practices is essential to the Ending the HIV Epidemic in the U.S. (EHE) initiative. It is imperative for these interventions to depict the work of diverse HIV providers presenting strategies to effectively link, engage, and retain people with HIV in care. Ryan White HIV/AID Program (RWHAP)-funded agencies and other HIV organizations can utilize this guide to inform their evaluation processes, garner resources to enhance program implementation (e.g., hiring additional staff, evaluation support, additional program resources), and add to critical strategies needed to end the epidemic. EHE is a collaborative effort and can be achieved when all agencies, regardless of organizational capacity, are provided with the additional resources and guidance needed to evaluate their programs.

Description of the Intervention Model

The Whitman-Walker Health (WWH) Mobile Outreach Retention and Engagement (MORE) intervention increased retention and viral suppression among people with HIV through a tailored service delivery model, which includes increasing access to supportive services and providing HIV care services in community settings. MORE reaches over 3,600 WWH clients with HIV and increases retention in care by providing mobile medical care outside of clinical settings and expanded supportive services (e.g., rideshare services, flexible health center hours, food cards, referrals for mental health counseling). Since 2016, WWH has implemented the intervention in collaboration with the Washington AIDS Partnership (WAP) and the District of Columbia Department of Health (DC Health) HIV/AIDS, Hepatitis, STD and TB Administration (HASHTA).WWH received funding for MORE from WAP, DC Health HAHSTA, the Bristol Myers Squibb Foundation, MAC AIDS Fund, and ViiV Healthcare.

Research Design and Relevant Preliminary Findings

Upon enrollment, participants self-selected which of the three levels of the intervention (Low MORE, Medium MORE, Full MORE) would best meet their needs. The levels correspond to the type and the breadth and depth of supportive services available to participants. A total of 370 participants were enrolled in the MORE program (Full MORE n=137; Medium MORE n=94; Low MORE n=139) during the first five years of the program and were followed for at least one year after enrollment. Data including demographic characteristics, lab reports, and medical visit information were extracted from WWH's electronic medical records (EMR) and a retrospective, quasi-experimental research design was used to compare clinical outcomes between groups.

Overall, findings from this preliminary analysis demonstrate that Full MORE and Medium MORE participants were more likely, than Low MORE participants, to achieve viral load suppression because of their level of participation. Additionally, Full MORE participants were less likely to be lost to follow-up than participants in both the Medium and Low MORE groups.

Demographic Characteristics

Across all levels, MORE Program participants tended to be 45 years and older, assigned male at birth, non-Hispanic Black or African American, identify as gay or bisexual and were insured through Medicaid. More specifically, 43 percent (n=159/370) were between 25 to 44 years of age and 51 percent (n=187/370) were between 45 to 65 years of age. Most participants (74.3 percent, n=275/370) were assigned male at birth, and of participants who were transgender, the majority identified as transgender women 16 percent (n=58/370). The majority (85 percent, n=313/370) of all MORE participants identified as Black or African American. Over half, 53 percent (n=194/370) of all MORE participants identified as gay or bisexual. Over half (60 percent, n=208/370) of participants had Medicaid, and 21 percent (n=75/370) had Medicare.

However, the Full MORE participants were more likely than the Medium and Low MORE participants to be assigned female at birth, identify as transgender, non-Hispanic Black or African American, heterosexual, and to be insured through Medicaid (Table 1). The significance of these relationships will be explored in subsequent analyses.

Table 1. Demographic Characteristics of MORE Participants

	Level of MORE Services		
	Full MORE n=137 (%)	**Medium MORE** n=94 (%)	**Low MORE** n=139 (%)
Age Mean (SD)	45.8 (13.0 percent)	47.7 (12.8 percent)	47.7 (12.1 percent)
Sex Assigned at Birth			
Female	51 (37.2 percent)	13 (13.8 percent)	30 (21.6 percent)
Male	86 (62.8 percent)	81 (86.2 percent)	108 (77.7 percent)
Transgender			
Yes	30 (21.9 percent)	11 (11.7 percent)	18 (12.9 percent)
No	107 (78.1 percent)	83 (88.3 percent)	121 (87.1 percent)
Race			
Black or African American	128 (93.4 percent)	79 (84 percent)	106 (76.3 percent)
White	6 (4.4 percent)	9 (9.6 percent)	20 (14.4 percent)
Other	3 (2.2 percent)	6 (6.4 percent)	13 (9.4 percent)
Ethnicity			
Hispanic	4 (2.9 percent)	8 (8.5 percent)	12 (8.6 percent)
Non-Hispanic	127 (92.7 percent)	81 (86.2 percent)	123 (88.5 percent)
Sexual Orientation			
Gay	46 (34.3 percent)	49 (35.3 percent)	66 (47.5 percent)
Heterosexual	61 (45.5 percent)	30 (21.6 percent)	43 (30.9 percent)
Bisexual	13 (9.7 percent)	6 (4.3 percent)	14 (10.1 percent)
Other	14 (10.2 percent)	8 (8.5 percent)	16 (11.7 percent)
Insurance			
Medicaid	97 (70.8 percent)	48 (40.0 percent)	63 (52.5 percent)
Medicare	28 (20.4 percent)	15 (12.5 percent)	32 (26.7 percent)
Private	8 (5.85 percent)	19 (15.8 percent)	12 (10.0 percent)
Uninsured	4 (2.9 percent)	12 (10.0 percent)	13.(10.8 percent)

Viral Suppression

Viral suppression rates were similar across all levels of participation at baseline despite differing demographic characteristics. All three groups had improved viral suppression rates at their most recent viral load measurement, but the Full and Medium MORE groups achieved higher rates of viral suppression than the Low MORE participants (81 percent and 83 percent vs. 63.3 percent; Table 2).

Table 2. Baseline and Current Viral Suppression Rates by MORE Level

	Full MORE n=137	Medium MORE n=94	Low MORE n=139
Baseline Viral Suppression Rate	54.7 percent (n=75)	59.6 percent (n=56)	55.4 percent (n=77)
Current Viral Suppression Rate	81.0 percent (n=111)	83.0 percent (n=78)	63.3 percent (n=88)

Additionally, MORE participants were 3.2 times more likely to achieve viral load suppression during the fourth year of the program compared to the first year of the program.

Lost to Follow-up

Full MORE participants were less likely to be lost to follow-up than Medium or Low MORE participants (Table 3). Low MORE participants were twice as likely to be lost to follow-up than the Full MORE participants (20.1 percent vs 9.5 percent).

Table 3. Current Participant Status by MORE Level

	Full MORE n=137	Medium MORE n=94	Low MORE n=139
Active	72.3 percent (n=99)	44.6 percent (n=62)	58.3 percent (n=81)
Lost to Follow-Up*	9.5 percent (n=13)	14.4 percent (n=20)	20.1 percent (n=28)
Transfer/Moved/ Incarcerated	8.0 percent (n=11)	5.0 percent (n=7)	14.4 percent (n=20)
Deceased	10.2 percent (n=14)	3.6 percent (n=5)	6.5 percent (n=9)

**Lost to Follow-Up is defined as no medical or phlebotomy visit in the last 12 months*

Further Analysis Plans

Based on these promising preliminary findings, further analyses are planned to determine the significance of these results and explore predictors of viral suppression and retention in care using bivariate and logistic regression analyses.

Intervention at a Glance

This section provides an overview of Whitman-Walker Health's steps to implement the Mobile Outreach Retention and Engagement (MORE) intervention.

STEP 1	**Determine Participant Eligibility** MORE participants must be 18 or older, have a reactive HIV diagnosis with a detectable HIV viral load (<200 copies/mL), and/or have not attended an HIV care follow-up visit in the last six months.
STEP 2	**Develop Participant Referral System** WWH's Quality Improvement (QI) team conducts an EMR chart review twice per year to provide data on client retention in the MORE intervention. The MORE intervention also accepts ongoing internal referrals from clinical staff (e.g., Nurse Case Managers, Care Navigators, Medical Providers). Identified clients are connected to the Mobile Care Navigator (MCN). The MCN reviews each referred client's EMR chart to confirm eligibility and find contact information.

STEP 3

Conduct Baseline Participant Interview

The MCN conducts the baseline interview at the initial point of client contact. The baseline interview includes a brief "pitch" on the MORE intervention, a discussion about the client's willingness to participate and assessing the client's self-reported HIV medical care and supportive service needs. The MCN will schedule a follow-up meeting if they cannot complete an initial interview.

STEP 4

Participants Self-Select Level of Program Engagement

Participants self-select which three program levels (Low MORE, Medium MORE, Full MORE) meet their needs.

Low MORE participants receive:

- Medical visits at the health center
- Phlebotomy at the health center during standard hours
- Medical insurance sponsored transportation, tokens, or SmarTrip (metro-rail) cards

Medium MORE participants receive:

- Medical visits at the health center
- Phlebotomy at the health center during standard hours
- Medical insurance sponsored transportation, tokens, or SmarTrip (metro-rail) cards
- Care navigation support from Care Navigators (CN) at the health center

Full MORE participants receive:

- Mobile medical visits in-home or at a location of the client's choice with a Mobile Advanced Practice Practitioner (MAPP)
- Medical visits at the health center with flexible hours with a MAPP, or during regular hours with an internal primary care physician
- Mobile phlebotomy services at home, location of the patient's choice, or at Health Center during standard hours
- Medical insurance sponsored transportation, tokens, rideshare services (Uber/Lyft), or SmarTrip (metro-rail) cards
- Care navigation support from Mobile Care Navigators in their home, a location of patient's choice, or in the health center

STEP 5 	**Implement the Intervention** MORE participants are eligible for all benefits associated with the engagement level of their choosing and can access all services within WWH's two health centers. Mobile Advanced Practice Practitioners (MAPPs) and MCNs provide care and coordinate supportive services for clients (see Required Staffing and Considerations). MORE clients receive services for the duration of their engagement in the program and can cease participation at any time.
STEP 6 	**Conduct Rolling Enrollment – "Recapture Blitz"** WWH conducts periodic EMR reviews to assess if there are new or other patients who meet the eligibility criteria. "Recapture Blitz" is a data to care effort between DC Health and RWHAP providers to identify clients who are out of care and ensures that these individuals can participate in the intervention.
STEP 7 	**Evaluate Intervention Effectiveness** Evaluate the intervention by utilizing client EMRs to assess retention and viral load suppression rates.

Securing Buy-In

External Stakeholders

WWH involved multiple stakeholders throughout the implementation and evaluation process to disseminate information about the purpose of the MORE intervention, clarify the need for non-traditional service delivery methods, and provide space for input from community members with HIV. Additionally, staff convened monthly meetings with funders, local community members, and other community-based organizations. WWH also partnered with and compensated members of the local RWHAP and HIV Prevention Steering Committees to gather recommendations. To maintain engagement, the team routinely updated stakeholders on progress (e.g., publishing reports and sending email updates).

Internal Stakeholders

Initially, meetings were held with WWH's CEO, Chief Health Officer, and Chief Program Officer to provide context on the need for non-traditional service delivery strategies and review the proposed intervention processes. The MORE team held recurring meetings with other WWH staff (e.g., medical providers, population health and quality staff, compliance, nurses, care navigation staff) to provide context on the need for the intervention. Meetings enhanced WWH staff's ability to be well-versed and tailor messaging to potential clients to increase intervention referrals. Meetings also provided staff with participant survey data and anecdotal feedback from clients engaged in the intervention.

Required Staff Resources & Cost Considerations

The following staff implemented the intervention at WWH, health centers, and in non-clinical settings:

Mobile Advanced Practice Practitioner (MAPP)

The MAPP is an advanced practice practitioner (either PA-C or NP) responsible for providing clinical follow-up primarily to participants who elect the Medium or Full MORE engagement level. MAPPs may also see Low MORE participants during their onsite medical hours or as their patient panels. Ideally, two part-time MMPs should be hired. The MAPP's responsibilities include:

- Provide medical care (e.g., treatment, evaluation, monitoring vitals, filling prescriptions and refills) in the client's home or other community site;
- Obtain and review the standard of care laboratory assessments to develop a treatment plan with the client;
- Evaluate and treat urgent medical issues (e.g., upper respiratory infections, rash);
- Initiate referrals to specialty medical, emergency rooms, and internal WWH services (e.g., STD testing and treatment, mental health services); and
- Set a treatment plan.

Mobile Care Navigator (MCN)

The MCN is the primary person to help clients navigate their HIV care and access other services. Ideally, two full-time MCNs should be hired. The MCN's responsibilities include:

- Coordinate the scheduling of home visits, pop-up visits, and medical appointments with the client and WWH care team and accompany clients to appointments;
- Coordinate the rescheduling of specialty medical appointments or visits to WWH health centers on behalf of the client;
- Conduct adherence follow up, troubleshoot issues related to accessing antiretroviral (ARV) prescriptions (e.g., pharmacy barriers);
- Provide health education on managing other diagnoses (e.g., STDs, hypertension);
- Routinely ask clients to self-report missed ARV doses and current mood;
- Review EMRs to stay updated on client progress, lab results, and general encounter history;
- Use motivational interviewing and harm reduction techniques to provide routine follow-up, assess medical needs and health status; and
- Work with clients and other WWH staff to ensure internal and external supports are easily accessible to clients.

Manager of Retention and Engagement

The Manager of Retention and Engagement is the intervention administrator and may fill the role of Mobile Care Navigator (MCN) as needed. The Manager provides supervision to MCNs and receives supervision from WWH's Chief Operations Officer. Ideally, one full-time Manager of Retention and Engagement should be hired. Their responsibilities include:

- Inform best practices for retention and engagement through evidence-based and collaborative approaches with community partners;
- Coordinate and provide culturally relevant and holistic services to clients at partnering organizations; and
- Provide internal support to other team members.

Staff Characteristics and Training

WWH provides all staff with position and project-specific training to establish a baseline of knowledge to enhance the delivery of agency programs, including the MORE intervention. These trainings include:

- Two-day EMR training to improve navigation;
- Comprehensive HIV training, including effective client engagement strategies and social determinants of health that impact access to care and retention;
- Motivational interview training for MCNs;
- Quarterly trainings for MCNs hosted by DC Health as part of the Case Management Operating Committee (See Additional Resources Box);
- Trainings to increase understanding of frequently occurring comorbidities;
- Brief action plan training; and
- Phlebotomy training to conduct blood draws in community settings.

Core competencies for staff included:

Manager of Retention and Engagement

- Ability to make strategic partnerships with other agencies providing services to people with HIV;
- Knowledge and ability to implement trauma-informed care practices; and
- Ability to develop and implement action plans.

Mobile Advanced Practice Practitioners (MAPPs)

- Willingness to provide medical services within mobile outreach and clinical settings;
- Demonstrated ability to work with diverse client populations affected by HIV, including persons with mental and behavioral health conditions;
- Knowledge and ability to implement trauma-informed care practices;
- Ability to obtain American Academy HIV Specialist (AAHIVS) Certification; and
- Working knowledge of structural determinants of health.

Mobile Care Navigators (MCNs)

- Knowledge of available local supportive services for people with HIV;
- Can-do attitude, good communication, flexibility, and organizational skills;
- Experience with client navigation or prior work at community-based HIV organizations;
- Working knowledge of structural determinants of health;
- Knowledge and ability to implement trauma-informed care practices; and
- Demonstrated ability to work with diverse client populations affected by HIV, including persons with mental and behavioral health conditions.

Cost Analysis

Funding for the MORE intervention supports providing HIV medical care inside and outside of clinical settings and other supportive services (e.g., transportation services, food access) for people with HIV.

The total cost for implementing the MORE intervention at two federally qualified health centers with mobile medical services was estimated at $347,098 annually ($4,285 per client) including indirect costs. This estimate includes salaries for two data managers/mobile developers, two care coordinators, two medical service providers, a social worker, and a medical director, direct program costs (i.e., staff computer-related expenses, medical supplies), and client-specific costs (i.e., food vouchers, educational materials, transportation related costs).

This high-level overview provides a snapshot of general costs based on available data from Whitman-Walker Health. Organizations interested in estimating the cost of implementing this intervention in their jurisdiction are encouraged to utilize the CIE Cost Calculator Tool (See Additional Resources Box).

Best Practices

The MORE team considered provider costs, utilized feedback from clients, and accounted for the size of their service area to make significant design and implementation decisions. This section highlights best practices the MORE team recommends using to implement the intervention:

Allot sufficient time to conduct home visits: It only took MORE staff an average of twenty minutes to reach a client's home. They also considered how many clients could be seen compared to the number of staff available to conduct home visits.

Provide flexible hours for patients: Is there sufficient designated space (i.e., enough exam rooms) in the clinic available for MORE medical visits?

Secure funding for MAPP and MCN time: Provider time for home visits was funded initially through RWHAP Part B reimbursement, but this does not account for travel time or "flexible time."

Cover staff travel/transportation costs: External funding sources such as RWHAP or grant funding will need to be identified to sustain transportation costs.intervention team works with staff to agree on expectations around communication, dress code, and work schedule (e.g., traditional work schedule, flexing time, etc.).

Use cost-sharing to assist with clients' provider preferences: Clients wishing to stay with their original provider (rather than a MORE provider) may do so if their provider bills some of their time to the MORE intervention for flexible time or home visits.

Overcoming Barriers

This section provides an overview of the barriers to implementation, as well as solutions identified by the MORE intervention team.

Low internal buy-in: The intervention team facilitated informational sessions with internal providers to demonstrate how the MORE intervention enhances HIV care for WWH clients.

Staff turnover and burnout: The intervention team worked with WWH leadership to reduce the number of assigned patients to make caseloads more manageable for staff. Additionally, the team identified clients with the highest needs and offered to rotate staff to have multiple individuals helping the client rather than one staff member. The intervention team also recognized that investment in staff meant providing more opportunities for continued education and upward mobility.

Inconsistent client internet and phone access: The intervention team includes phones and phone minutes in grant budget proposals to address internet connectivity and access barriers.

Funding for MAPPs and MCNs time and transportation: The intervention team conducted a comprehensive evaluation to provide outcome data with the intention to apply for additional funding to cover these costs.

Hesitancy to see a new provider: Clients hesitant to see a MORE provider instead of their internal provider have the option to continue seeing their internal provider (non-MORE clinical providers) and use the MAPP as needed. Internal providers work closely with the MAPPs to coordinate care for shared clients.

Difficulty connecting patients to appropriate psychiatric care: WWH does not provide psychiatric care to MORE participants. The intervention team mitigated this by establishing strong and more direct relationships with Core Service Agencies (CSA) in the DC Metropolitan area. The intervention team is also considering adding a psychiatric provider to the MORE team.

The Impact of COVID-19

Coronavirus disease 2019 (COVID-19) forced the United States health care system to change and adapt in many ways. One change that the health care system was forced to do early on was to minimize in-person healthcare visits to reduce the risk of exposure to healthcare providers and clients. Reduced in-person visits resulted in healthcare providers discontinuing or transitioning non-COVID-19 related services to telehealth. Reducing access to in-person HIV services has significantly reduced access to ART services and routine viral load testing.1 Whitman-Walker Health (WHH) was forced to close its health centers for non-COVID-19 related appointments. As a result, MORE staff provided services via telehealth, audio-only (phone call) visits, and text check-ins for clients who had access to a smartphone or computer. Clients needing phlebotomy services during that time received referrals to LabCorp for off-site services. Additionally, MCNs and MAPPs were trained on telehealth and COVID-19 prevention measures to support MORE clients as well as other WWH patients. MAPPs offered medical care to COVID-19 patients within the health centers in addition to their MORE telehealth visits. Once the health center reopened to provide primary care services, MCNs provided "greeter services" (i.e., symptom screening, temperature checks) to clients in addition to their MORE intervention responsibilities. Even as COVID-19 cases in DC declined, the intervention team could not provide services to MORE clients within the health center due to the lack of space to conduct visits.

Additionally, MORE participants that continued to receive services during the pandemic also experienced limited phone and computer access, limited ability to participate in audio-visual visits, food insecurity, limited access to medications, limited transportation, decreased ability to access non-COVID-19 related medical care, and reduced capacity to quarantine or isolate due to their living situations. Staff tried to mitigate these challenges by identifying other community resources from organizations like Mutual Aid and DC Greens program (food access program). MORE staff also identified other measures to make their services more equitable by using MCNs to help facilitate the delivery of medications for clients with limited access to transportation.

Sustainability and Capacity Building

The MORE team previously analyzed program outcome indicators but has been unable to conduct a high-quality analysis due to limited staff time and lack of statistical expertise. After participating in the CIE Equity in Evaluation Project, MORE the team plans to use the assigned Evaluator's recommendations to enhance future evaluation processes, submit an abstract or manuscript for academic review, and use outcome data to advocate for additional funding to expand the intervention. The team also plans to increase their internal evaluation activities by annually evaluating outcomes between Low and Medium MORE engagement in comparison to Full MORE engagement.service programs that provide equitable, anti-racist, and culturally appropriate services. Staff also recognized that ART adherence is difficult for many clients with non-medical needs (e.g., transportation, employment assistance, food vouchers, etc.). The team is investigating the availability of other unrestricted funding to cover these expenses and continues to work with MDHHS to advocate for additional support to address clients' non-medical needs.

"The CIE project offered us an invaluable opportunity to evaluate our work through the lens of experts and to provide us with tools to disseminate our experience properly."

– MOBILE ADVANCED PRACTICE PRACTITIONER

To ensure sustainability, WWH worked closely with their local health department to assess if RWHAP funds could cover medical services in the home and non-medical case management services offered by MCNs. Although funding does not cover the entire initiative, the MORE team plans to use findings from the analysis of this intervention to demonstrate the need for additional support. With additional funding, the MORE team plans to improve internal marketing, incentivize client participation, cover transportation-related expenses for staff (e.g., gas, parking, mileage reimbursement), and increase wages and staff time for MAPPs and MCNs.

Conclusion

The dissemination of evidence-based (EBI) and evidence-informed (EII) interventions plays an essential role in Ending the HIV Epidemic (EHE) in the U.S. Organizations often seek out these interventions during EHE planning and influence funding decisions and program implementation. However, the evaluation and research processes needed to be considered an EBI or EII often exclude underfunded organizations with limited evaluation and research capacity. Evidence-based and evidence-informed interventions are overwhelmingly produced by academic institutions or other well-resourced entities which have the capacity to evaluate data or conduct academic research effectively. Consequently, the innovative and responsive models of often less well-resourced community-based organizations, AIDS service organizations, grassroots initiatives, and organizations led by Black, Indigenous, and Other People of Color are often not as broadly circulated.

Addressing the inequities within evaluation and research requires increased investment in resources to build capacity among organizations to evaluate and disseminate innovative service delivery models. HRSA is committed to this effort by funding the Center for Innovation and Engagement (Evidence-Informed Approaches to Improving Health Outcomes for People with HIV project) as well as the RWHAP Recipient Compilation of Best Practice Intervention Strategies (Best Practices Compilation), led by John Snow Inc. (JSI) (See Additional Resources Box). The Best Practices Compilation identifies novel, emerging RWHAP interventions that have a real-world impact on improving health outcomes along the HIV Care Continuum and whose research is not published in peer-reviewed journals.

Additional Resources

DC Health Case Management Operation Committee: https://cmocdc.webs.com/aboutus.htm

Whitman-Walker Health MORE Program Website: https://www.whitman-walker.org/care-program/care-navigation-more-program

CIE Cost Analysis Calculator: http://ciehealth.org/innovations

TargetHIV Best Practices Compilation: https://targethiv.org/bestpractices

References

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